Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TARRANT COUNTY SURGICAL CENTER
914 LIPSCOMB STREET
FORT WORTH TX 76104

Carrier's Austin Representative Box

Box Number 47

MFDR Date Received

MAY 10, 2011

Respondent Name

TRANS PACIFIC INSURANCE CO

MFDR Tracking Number

M4-11-3061-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claim for our Patient [Claimant], was denied for the {permanent spinal cord stimulator} procedure that took place on 01-12-2011 the reason it denied was due to 'No Authorization' approved for the Permanent, we had the 'Trial' Authorized, but failed in human error to get the Authorization for the Permanent Authorized…therefore, our claim was denied."

Amount in Dispute: $48,580.54

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Tarrant County Surgical Center has the burden to prove that pre-authorization was requested and given. Before pre-authorization was given for the trial of the stimulator, which was performed, pre-authorization was never requested nor given for the permanent implantation of the device…As pre-authorization was not requested, under Division Rule 134.600, Tokio Marine is not liable for reimbursement."

Responses Submitted by: Burns Anderson Jury & Brenner, L.L.P.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 12, 2011	ASC Services for Codes: 63685-SG, 63650-SG, L8681-SG (X2), L8689-SG, and L8680-SG	$48,580.54	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.600, effective May 2, 2006, 31 TexReg 3566, requires preauthorization for

ambulatory surgical center services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 39-Services denied at the time authorization/precertification was requested.
   - W1-Workers compensation state fee schedule adjustment.
   - 214 Workers compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment.
   - W2-Workers compensation claim adjudicated as non-compensable. Carrier not liable for claim or service/treatment.

Issues

1. Does a preauthorization issue exist in this dispute? Is the requestor entitled to reimbursement?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for the disputed services based upon reason code "39."

   The requestor states "…we had the 'Trial' Authorized, but failed in human error to get the Authorization for the Permanent Authorized."

   The respondent states "pre-authorization was never requested nor given for the permanent implantation of the device…As pre-authorization was not requested, under Division Rule 134.600, Tokio Marine is not liable for reimbursement."

   28 Texas Administrative Code §134.600(p)(2) states "Non-emergency health care requiring preauthorization includes: outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section."

   The requestor indicated that preauthorization was not obtained for the disputed services; therefore, a preauthorization issue exists in this dispute. As a result, reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	06/12/2013 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.